

		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045443

Facility Name: Addolorata Villa

Address: 555 McHenry Road Wheeling 60090

County: Cook

Telephone Number: (847)215-5801 Fax # (847)215-5805

IDPA ID Number: 364107655-001

Date of Initial License for Current Owners: 11/27/96

Type of Ownership:

☒

VOLUNTARY,NON-PROFIT

☒

Charitable Corp.

☐

Trust

IRS Exemption Code 501(c)(3)

☐

PROPRIETARY

☐

Individual

☐

Partnership

☐

Corporation

☐

"Sub-S" Corp.

☐

Limited Liability Co.

☐

Trust

☐

Other

☐

GOVERNMENTAL

☐

State

☐

County

☐

Other

In the event there are further questions about this report, please contact:
Name:: Steve Lavenda Telephone Number: (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2000 to 06/30/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name)

(Title)

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) Steven N. Lavenda, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Addolorata Villa

0045443 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 5/1/01

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>88</u>	Skilled (SNF)	<u>88</u>	<u>32,120</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>10</u>	Intermediate (ICF)	<u>10</u>	<u>3,650</u>	3
4		Intermediate/DD			4
5	<u>45</u>	Sheltered Care (SC)	<u>43</u>	<u>16,303</u>	5
6		ICF/DD 16 or Less			6
7	<u>143</u>	TOTALS	<u>141</u>	<u>52,073</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,706</u>	<u>22,884</u>	<u>1,270</u>	<u>30,860</u>	8
9	SNF/PED					9
10	ICF	<u>595</u>	<u>2,744</u>		<u>3,339</u>	10
11	ICF/DD					11
12	SC		<u>9,440</u>	<u>925</u>	<u>10,365</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,301</u>	<u>35,068</u>	<u>2,195</u>	<u>44,564</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.58%

D. How many bed-hold days during this year were paid by Public Aid? 25 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) Outpatient Therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☒ NO ☐

I. On what date did you start providing long term care at this location? Date started 11/27/96

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 11/27/96 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 7 and days of care provided 1175

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 6/30/01 Fiscal Year: 6/30/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Addolorata Villa # 0045443 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	426,095	84,074	6,076	516,245		516,245	(87,704)	428,541			1
2	Food Purchase		265,137		265,137		265,137	(43,448)	221,689			2
3	Housekeeping	241,133	52,586	917	294,636		294,636	(23,042)	271,594			3
4	Laundry	40,367	22,277		62,644		62,644	(4,128)	58,516			4
5	Heat and Other Utilities			86,426	86,426		86,426	(19,074)	67,352			5
6	Maintenance	258,834	61,864	180,535	501,233		501,233	(49,816)	451,417			6
7	Other (specify):*											7
8	TOTAL General Services	966,429	485,938	273,954	1,726,321		1,726,321	(227,212)	1,499,109			8
	B. Health Care and Programs											
9	Medical Director			9,313	9,313		9,313		9,313			9
10	Nursing and Medical Records	2,265,689	98,648	291,044	2,655,381		2,655,381		2,655,381			10
10a	Therapy	99,249			99,249		99,249		99,249			10a
11	Activities	151,121	16,510	10,908	178,539		178,539		178,539			11
12	Social Services	138,476	1,387	21,540	161,403		161,403	(141)	161,262			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,654,535	116,545	332,805	3,103,885		3,103,885	(141)	3,103,744			16
	C. General Administration											
17	Administrative	35,608			35,608		35,608	(275)	35,333			17
18	Directors Fees											18
19	Professional Services			285,408	285,408		285,408	(37,760)	247,648			19
20	Dues, Fees, Subscriptions & Promotions			78,531	78,531		78,531	(14,433)	64,098			20
21	Clerical & General Office Expenses	351,333	25,454	502,130	878,917		878,917	(445,219)	433,698			21
22	Employee Benefits & Payroll Taxes			746,767	746,767		746,767	(22,785)	723,982			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,011	8,011		8,011	(6,691)	1,320			24
25	Other Admin. Staff Transportation			11,475	11,475		11,475	(9,476)	1,999			25
26	Insurance-Prop.Liab.Malpractice			34,424	34,424		34,424	(7,242)	27,182			26
27	Other (specify):*											27
28	TOTAL General Administration	386,941	25,454	1,666,746	2,079,141		2,079,141	(543,881)	1,535,260			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,007,905	627,937	2,273,505	6,909,347		6,909,347	(771,234)	6,138,113			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			485,475	485,475		485,475		485,475			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			545,729	545,729		545,729	(406,362)	139,367			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			194,297	194,297		194,297		194,297			36
37	TOTAL Ownership			1,225,501	1,225,501		1,225,501	(406,362)	819,139			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	100,720	512,411	39,262	652,393		652,393		652,393			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			5,677	5,677		5,677	(5,677)	0			41
42	Provider Participation Fee			58,800	58,800		58,800		58,800			42
43	Other (specify):*	775,439	284,121	2,095,365	3,154,925		3,154,925	(3,154,925)	0			43
44	TOTAL Special Cost Centers	876,159	796,532	2,199,104	3,871,795		3,871,795	(3,160,601)	711,194			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,884,064	1,424,469	5,698,110	12,006,643		12,006,643	(4,338,198)	7,668,445			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,018)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(5,888)	6		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(343,738)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,256)	20		20
21	Owner or Key-Man Insurance	(7,242)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,936,241)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,302,383)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(35,815)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (35,815)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (4,338,198)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
	Reference		
1	Printing and copy	(686)	20 1
2	Gain/Loss sale of security	(12,792)	21 2
3	Unrealized gain/loss) inc	(266,554)	21 3
4	Admn-bank/service charges	(7,853)	21 4
5	DVLP-annuity interest	(7,095)	32 5
6	Interest expense-ILU	(37,885)	32 6
7	MKT-director prod	(2,776)	43 7
8	MKT-assistant prod	(48,310)	43 8
9	MKT-secretary prod	(14,130)	43 9
10	DVLP-asst dir	(79,873)	43 10
11	DVLP-admin asstnt-productive	(15,629)	43 11
12	SSTR-manager wages	(22,540)	43 12
13	ILU-dir of acct prod	(29,960)	43 13
14	ILU-clinical nurse	(18,200)	43 14
15	ILU-manager	(24,957)	43 15
16	ILU-driver	(13,030)	43 16
17	MKT-postage/freight	(161)	43 17
18	MKT-general office exp	(5,453)	43 18
19	DVLP-general supplies	39	43 19
20	DVLP-FQV gen supplies	(25,536)	43 20
21	SSTR-fuel & gas	(2,497)	43 21
22	SSTR-light & power	(2,102)	43 22
23	SSTR-rent	(23,400)	43 23
24	SSTR-disposal service	(2,520)	43 24
25	SSTR-Supplies Exp	(492)	43 25
26	SSTR-telephone expense	(701)	43 26
27	SSTR-water & sewer	(697)	43 27
28	ILU-subscriptions/dues	(191)	43 28
29	ILU-ARA function	(4,203)	43 29
30	ILU-misc expense	(802)	43 30
31	MKT-general supplies	(20,031)	43 31
32	ILU-special serv exps	(2,892)	43 32
33	MKT-subscriptions/dues	(4,920)	43 33
34	MKT-employee travel	(1,124)	43 34
35	MKT-miscellaneous exp	(1,190)	43 35
36	MKT-printing/copying	(19,467)	43 36
37	MKT-promo/advertis	(38,482)	43 37
38	DVLP-consultant fees	(96,000)	43 38
39	DVLP-golf outing	(35,282)	43 39
40	DVLP-misc. expenses	(29,820)	43 40
41	DVLP-printing & copying	(5,246)	43 41
42	DVLP-promo/adv.	(28,550)	43 42
43	DVLP-seminar/conference	(495)	43 43
44	Other-gift shop revenue	(5,659)	41 44
45	Other-misc revenue	(9,951)	21 45
46	Employee health ins	(6,960)	22 46
47	HR-physicals	(192)	22 47
48	MSSN-day of reflection	(141)	12 48
49	On service-function	(21,042)	01 49
50	KTCT-rending revenue	(18)	41 50
51	Capitalized Interest Expensed	(17,133)	32 51
52	ILU-Supplies Reclassified	(255,010)	43 52
53	ILU-Other Reclassified	(1,774,252)	43 53
54	ILU-Salary Reclassified	(421,679)	43 54
55	Garden Cafe	(13,319)	43 55
56	Convent Dietary	(66,689)	1 56
57	Convent Food	(38,430)	2 57
58	Convent Housekeeping	(23,042)	3 58
59	Convent Laundry	(4,120)	4 59
60	Convent Utilities	(19,074)	5 60
61	Convent R&M	(43,928)	6 61
62	Convent Clerical & Office	(65,368)	21 62
63	Seminar Expense	(6,691)	24 63
64	Legal Accruals/Expense	(33,158)	19 64
65	Admin Consulting	(4,602)	19 65
66	Other Admin. Staff Travel	(9,166)	35 66
67	Late Fees	(511)	32 67
68	Misc Pri Pay	(11,869)	21 68
69	Misc Medicaid	(15,453)	21 69
70	Misc Medicare	(7,765)	21 70
71	Admin Misc Expense	(43,697)	21 71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90			90
91			91

Summary A

06/30/2001

[illegible]

Summary B

06/30/2001

[illegible]

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	\$ 15,600	Franciscan Sisters Service Corporation	100.00%	\$ 15,600	\$	15
16	V	17	Administrative	18,969	Franciscan Sisters Service Corporation	100.00%	18,694	(275)	16
17	V	19	Management Fees	195,584	Franciscan Sisters Service Corporation	100.00%	195,584		17
18	V	19	Professional Fees	17,798	Franciscan Sisters Service Corporation	100.00%	17,798		18
19	V	20	Dues, Fees, Subscriptions & Promotions	9,689	Franciscan Sisters Service Corporation	100.00%		(9,689)	19
20	V	21	Clerical and General Office Expenses	22,068	Franciscan Sisters Service Corporation	100.00%	12,151	(9,917)	20
21	V	22	Employee Benefits	15,624	Franciscan Sisters Service Corporation	100.00%		(15,624)	21
22	V	25	Other Admin. Staff Transportation	310	Franciscan Sisters Service Corporation	100.00%		(310)	22
23	V	36	Bond Fees	81,334	Franciscan Sisters Service Corporation	100.00%	81,334		23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 376,976			\$ 341,161	\$ * (35,815)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Ending: 6/30/2001

Fax Number

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Ending: 6/30/2001

(708)647-6982

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing and Medical Records	Direct Allocation			\$	\$		\$ 15,600	1
2	17	Administrative	Direct Allocation						18,694	2
3	19	Management Fees	Direct Allocation						195,584	3
4	19	Professional Fees	Direct Allocation						17,798	4
5	20	Dues, Fees, Subscriptions & Prom	Direct Allocation							5
6	21	Clerical and General Office Exper	Direct Allocation						12,151	6
7	22	Employee Benefits	Direct Allocation							7
8	25	Other Admin. Staff Transportatio	Direct Allocation							8
9	36	Bond Fees							81,334	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 341,161	25

Ending: 6/30/2001

Fax Number

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Ending: 6/30/2001

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Ending: 6/30/2001

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Ending: 6/30/2001

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Ending: 6/30/2001

Fax Number

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Ending: 6/30/2001

Fax Number

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Ending: 6/30/2001

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Ending: 6/30/2001

Fax Number

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	IFA Series 1996 D Bonds		X	Acquisition of assets	\$45,370	11/27/96	\$ 6,095,000	\$ 5,405,000	5/15/19	5.0-7.0%	\$ 377,275	1	
2	IFA Series 1996 E Bonds		X	Acquisition of assets	Variable Debt	11/27/96	5,660,000	5,660,000	5/15/27	Variable	217,518	2	
3	IFA Series 1996 F Bonds		X	Acquisition of assets	Variable Debt	11/27/96	6,340,000				203,962	3	
4	Long Term Debt Payable					2001		15,090,000			215,188	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$45,370		\$ 18,095,000	\$ 26,155,000			\$ 1,013,943	9	
	B. Non-Facility Related*												
10	See Supplemental Schedule										(874,576)	10	
11	Interest Expense - ILU										37,885	11	
12	ILU Interest P. 5A Adjust										(37,885)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (874,576)	14	
15	TOTALS (line 9+line14)						\$ 18,095,000	\$ 26,155,000			\$ 139,367	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number

Addolorata Villa

0045443

Report Period Beginning:

07/01/2000

Ending:

06/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
1	Capitalized Interest Expensed						\$					\$	17,133	1
2	Cap Int Adjusted on P.5A												(17,133)	2
3	Interest Income												(343,738)	3
4	DVLP-Annuity Interest												7,095	4
5	Annuity Interest - Adj on P.5A												(7,095)	5
6	Interest Expense Allocated to													6
7	ILU, Reclassified to Line 43													7
8	and adjusted out on P. 5A												(530,327)	8
9	Late Fees												(511)	9
10														10
11														11
12														12
13														13
14														14
15														15
16														16
17														17
18														18
19														19
20														20
21							\$		\$			\$	(874,576)	21

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY IDPH LICENSE NUMBER 0045443

TELEPHONE () FAX #: ()

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,613

B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Addolorata Villa Independent Living Units 80,036 square feet, 100 units

Outpatient Therapy - 2,332 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Healthcare	6.125	1996	\$ 644,128	1
2					2
3	TOTALS	6		\$ 644,128	3

See Page 12A, Line 70 for total

****Improvement type must be detailed in order for the cost report to be considered complete.**

06/30/2001

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

****Improvement type must be detailed in order for the cost report to be considered complete.**

****Improvement type must be detailed in order for the cost report to be considered complete.**

****Improvement type must be detailed in order for the cost report to be considered complete.**

06/30/2001

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

****Improvement type must be detailed in order for the cost report to be considered complete.**

06/30/2001

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,941,307	\$ 287,268		\$ 287,268	\$	\$ 1,270,921	1
2	orig - chapel revovation: hvac	1997	37,140	2,631	15	2,631		9,208	2
3	orig - chapel revovation: stained windows	1997	41,625	2,775	15	2,775		9,713	3
4	orig - chapel revovation: marble	1997	26,758	1,784	15	1,784		6,243	4
5	orig - chapel revovation: roofing	1997	14,363	1,015	15	1,015		3,551	5
6	orig - chapel revovation: carpet	1997	890	178	5	178		623	6
7	orig - chapel revovation: plumbing	1997	7,139	595	15	595		2,082	7
8	orig - carpet	1998	19,465	4,526	5	4,526		15,842	8
9	orig - hvac glyucose treatment	1997	10,771	718	15	718		2,513	9
10	orig - hvac glyucose treatment	1998	10,840	723	15	723		2,529	10
11	orig - computer network cabling	1997	11,826	788	15	788		2,759	11
12	orig - electrical improvements	1998	6,485	432	15	432		1,513	12
13	orig - mechancial rooftop drain	Aug-97	570	38	15	38		133	13
14	orig - plumbing comosite	Aug-97	547	27	20	27		96	14
15	orig - new ceiling scf 214	Aug-97	983	66	15	66		230	15
16	orig - mckesson single vac with recvler	Nov-97	2,246	225	10	225		786	16
17	orig - main sign	Dec-97	1,924	128	15	128		449	17
18	orig - water conditioner	Dec-97	874	87	10	87		306	18
19	orig - business office laminate counter	Dec-97	988	69	15	69		230	19
20	orig - business office laminate mail boxes	Dec-97	1,431	95	15	95		334	20
21	orig - closet organizers intermrdate rooms	Jan-98	809	54	15	54		189	21
22	orig - convent dishwasher and plumbing	Jan-98	2,328	466	5	466		1,629	22
23	orig - water system piping	Mar-98	1,503	100	15	100		351	23
24	orig - sheltered care air vents	Mar-98	1,042	69	15	69		243	24
25	orig - chair rail replacement	Apr-98	2,085	139	15	139		486	25
26	orig - signage	Apr-98	1,225	82	15	82		286	26
27	orig - production room mill work	Apr-98		188	15	188		660	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,147,164	\$ 305,266		\$ 305,266	\$	\$ 1,333,905	34

****Improvement type must be detailed in order for the cost report to be considered complete.**

06/30/2001

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

****Improvement type must be detailed in order for the cost report to be considered complete.**

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	furnish 2-1/2 ton condensing unit			Apr-01	867	29	15	29		29	9
10	address snu aaon rtu problems			Apr-01	3,982	133	15	133		133	10
11	asbestos abatement			Apr-01	1,276	128	5	128		128	11
12	porcelain refinishing			Apr-01	918	92	5	92		92	12
13	audio/video modulator			Apr-01	547	27	10	27		27	13
14	paint			Apr-01	1,678	168	5	168		168	14
15	rooftop repairs			May-01	784	26	15	26		26	15
16	ac hookup			May-01	738	25	15	25		25	16
17	rooftop low voltage			May-01	1,303	43	15	43		43	17
18	sheltered rehab work			May-01	1,990	66	15	66		66	18
19	mary's room shower conversion			May-01	2,750	69	20	69		69	19
20	install new p.lam. cabinets, counter top and plumbing			May-01	5,200	130	20	130		130	20
21	replace defective condenser			May-01	2,921	97	15	97		97	21
22	repair automation system			May-01	1,061	27	20	27		27	22
23	furnish and install dampers			May-01	1,768	59	15	59		59	23
24	motor blower			May-01	496	50	5	50		50	24
25	paint			May-01	421	42	5	42		42	25
26	paint			May-01	724	72	5	72		72	26
27	paint			Jun-01	1,041	104	5	104		104	27
28	paint			Jun-01	708	71	5	71		71	28
29	ucci			Jun-01	5,948	149	20	149		149	29
30	scf project cip 2001 transfer			Jun-01	409,115	10,228	20	10,228		10,228	30
31	adjust depreciation to trial balance					(123,617)		(123,617)		(102,019)	31
32	Allocated to Outpatient Therapy Per 6/30/00 Cap Report			2000	(41,623)						32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 404,610	\$ (111,783)		\$ (111,783)	\$	\$ (90,185)	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,022,952	\$139,550	\$139,550	\$		\$412,243	71
72	Current Year Purchases	75,741	5,743	5,743			5,743	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,098,693	\$145,293	\$145,293	\$		\$417,986	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocation to SNF	Illinois BUS	2001	\$11,548	\$1,443	\$1,443	\$		\$1,443	76
77										77
78										78
79										79
80	TOTALS			\$11,548	\$1,443	\$1,443	\$		\$1,443	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$11,160,861	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$485,475	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$485,475	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,816,190	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non-Healthcare Assets	\$8,381,336	\$569,905	\$1,669,288	86
87	6/30/00 Capital Report Adjustments	212,966			87
88	Outpatient Therapy	41,263			88
89					89
90					90
91	TOTALS	\$8,635,565	\$569,905	\$1,669,288	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease.

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO

16. Rental Amount for movable equipment: \$
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	\$
13.	/2003	\$
14.	/2004	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

		1		2		3	4
		Facility		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$					
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$		\$		\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$					

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 172	\$		\$ 172	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			1,795			1,795	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	100,720		1,666	8,628		111,014	4
5	Physician Care		visits							5
6	Dental Care	39 - 03	visits			2,204			2,204	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				432,263		432,263	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					33,425	71,520		104,945	13
14	TOTAL			\$ 100,720		\$ 39,262	\$ 512,411		\$ 652,393	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
13A Nurs-oxygen supplies	15,289
13B Nurs-medical supplies	8,679
13C Nurs-other chargeable	47,552
13D	
13E	
13F	
13G	
13H	
13I	
13J	
	<u>71,520</u>
<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
13K Nurs-X-ray	33,425
13L	
13M	
13N	
13O	
13P	
13Q	
13R	
13S	
13T	
	<u>33,425</u>

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 937,963	\$	1
2	Cash-Patient Deposits	2,117		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,161,459		3
4	Supply Inventory (priced at)	61,500		4
5	Short-Term Investments	111,399		5
6	Prepaid Insurance	93,361		6
7	Other Prepaid Expenses	36,699		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	471,030		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,875,528	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,895,448		12
13	Land	1,850,000		13
14	Buildings, at Historical Cost	15,951,281		14
15	Leasehold Improvements, at Historical Cost	402,097		15
16	Equipment, at Historical Cost	1,524,257		16
17	Accumulated Depreciation (book methods)	(3,514,413)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	11,796,352		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	2,237,608		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 32,142,630	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 36,018,158	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,597,157	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	705,055		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	349,146		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	122,406		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	2,990,715		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,764,479	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	15,090,000		39
40	Mortgage Payable			40
41	Bonds Payable	11,065,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule	175,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 26,330,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 32,094,479	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,923,679	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 36,018,158	\$	48

*(See instructions.)

Other Current Assets:		Amount	Amount	Other Current Liabilities		Amount	Amount
09A	IDFA:LOC/MKT fees	9,216		36A	Endowment fund-Board	289,000	
09B	Current-trustee funds	175,000		36B	Board designated funds	1,750,000	
09C	Other current assets	8,711		36C	Advance billing-NH	551,261	
09D	Misc. receivables	12,545		36D	Advance billing-ILU	226,844	
09E	Employee loans	3,772		36E	Due from HCI	7,492	
09F	Gift certificate liability	1,232		36F	Amounts due IDPA	5,145	
09G	Unrealized Gain on Investment	260,554		36G	Due to FSCSC	160,973	
		471,030				2,990,715	
Other Non-Current Assets:		Amount	Amount	Other Non-Current Liabilities		Amount	Amount
23A	CIP-ALU	1,392,332		43A	Current trustee held	175,000	
23B	Deferred finance:1996	296,819		43B			
23C	2001 L.O.C. fee up front	137,700		43C			
23D	CVS-supplemental life	96,338		43D			
23E	2001 underwriters discount	85,505		43E			
23F	Series D orig discount	130,228		43F			
23G	Foundation Net Profit	98,686		43G			
		2,237,608				175,000	

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,744,718	1
2	Restatements (describe):		2
3	Unrestricted Assets Foundation	54,089	3
4	Plant Contrib - Foundations	40,483	4
5	Restricted Operations Contribution	15,545	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,854,835	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(931,156)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (931,156)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,923,679	24

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,929,982	1
2	Discounts and Allowances for all Levels	(1,085,773)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,844,209	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	278,693	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 278,693	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	41,932	12
13	Barber and Beauty Care	2,175	13
14	Non-Patient Meals	6,539	14
15	Telephone, Television and Radio	23,797	15
16	Rental of Facility Space	174,171	16
17	Sale of Drugs	388,700	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	836	19
20	Radiology and X-Ray	22,721	20
21	Other Medical Services	164,596	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 825,467	23
D. Non-Operating Revenue			
24	Contributions	66,583	24
25	Interest and Other Investment Income***	343,738	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 410,321	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	716,797	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 716,797	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,075,487	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,726,321	31
32	Health Care	3,103,885	32
33	General Administration	2,079,141	33
B. Capital Expense			
34	Ownership	1,225,501	34
C. Ancillary Expense			
35	Special Cost Centers	3,812,995	35
36	Provider Participation Fee	58,800	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,006,643	40
41	Income before Income Taxes (line 30 minus line 40)**	(931,156)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (931,156)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Supplemental Schedule of Revenues
06/30/2001

Description	Amount
28A Other-misc revenue	9,951
28B IDFA Trust income	83,119
28C Employee health ins	6,969
28D FND-corp support fee	96,000
28E Sisters store revenue	85,864
28F ILU-special ser revenue	18,690
28G HR-physicals	192
28H MSSN-day of reflection	141
28I Din service-function	21,015
28J KTCH-vending revenue	18
28K SS-Misc-Private pay	11,869
28L SS-Misc-Medicaid	15,453
28M SS-Misc-Medicare	7,765
28N Unrealized Gain on Investment	260,554
28O Foundation Net Profit	98,686
28P Late Fees	511
28Q	
28R	
28S	
28T	
Total	716,797

Facility Name & ID Number Addolorata Villa# 0045443

Report Period Beginning:

07/01/2000

Ending:

06/30/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,856	2,153	\$ 71,446	\$ 33.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,331	26,585	668,613	25.15	3
4	Licensed Practical Nurses	12,370	14,726	266,847	18.12	4
5	Nurse Aides & Orderlies	85,530	101,822	1,178,076	11.57	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,616	3,035	100,720	33.19	7
8	Rehab/Therapy Aides	5,770	6,694	99,249	14.83	8
9	Activity Director	1,948	2,260	38,431	17.00	9
10	Activity Assistants	10,226	11,862	112,690	9.50	10
11	Social Service Workers	7,689	8,919	138,476	15.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	32,954	38,227	426,095	11.15	15
16	Dishwashers					16
17	Maintenance Workers	12,355	14,332	258,834	18.06	17
18	Housekeepers	21,245	24,644	241,133	9.78	18
19	Laundry	3,837	4,451	40,367	9.07	19
20	Administrator					20
21	Assistant Administrator	1,221	1,416	35,608	25.15	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,079	18,652	351,333	18.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,985	5,783	80,707	13.96	31
32	Other Health Care(specify)					32
33	Other(specify)	41,342	47,957	775,440	16.17	33
34	TOTAL (lines 1 - 33)	284,354	333,518	\$ 4,884,065 *	\$ 14.64	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	81	\$ 6,076	01-03	35
36	Medical Director	75	9,313	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	273	15,284	10-03	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	210	10,908	11-03	44
45	Social Service Consultant	302	16,010	12-03	45
46	Other(specify)				46
47	Priest Stipends		5,140	12-03	47
48	Pastoral Consultant		390	12-03	48
49	TOTAL (lines 35 - 48)	941	\$ 63,121		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4,758	\$ 223,638	10-03	50
51	Licensed Practical Nurses	35	1,273	10-03	51
52	Nurse Aides	2,825	50,849	10-03	52
53	TOTAL (lines 50 - 52)	7,618	\$ 275,760		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
33A Marketing Wages	2,553	2,962	\$ 102,164	\$ 34.49
33B Development Wages	4,141	4,804	95,503	19.88
33C SSTR-manager wages	2,050	2,378	22,548	9.48
33D Independent Living Unit	31,877	36,977	545,902	14.76
33E Garden Café	721	836	9,323	11.15
33F				
33G				
33H				
33I				
	41,342	47,957	\$ 775,440	\$ 16.17

(See instructions.)

[illegible]

Facility Name & ID Number		Addolorata Villa		STATE OF ILLINOIS	#	0045443	Report Period Beginning:	07/01/2000	Ending:	06/30/2001	Page 23
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>No</u>							
(2)	Are there any dues to nursing home associations included on the cost report?			<u>Yes</u>							
	If YES, give association name and amount.			<u>Life Services Network \$50</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization?			<u>No</u>							
	If YES, have these costs been properly adjusted out of the cost report?										
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?			<u>No</u>							
	If YES, what is the capacity?										
(5)	Have you properly capitalized all major repairs and equipment purchases?			<u>Yes</u>							
	What was the average life used for new equipment added during this period?			<u>10 Years</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$	<u>39,273</u>	Line	<u>10</u>				
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?			<u>Yes</u>							
	If NO, attach a complete explanation.										
(8)	Are you presently operating under a sale and leaseback arrangement?			<u>No</u>							
	If YES, give effective date of lease.										
(9)	Are you presently operating under a sublease agreement?			YES	<u>X</u>	NO					
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?			YES		NO	<u>X</u>	If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.			\$	<u>58,800</u>	This amount is to be recorded on line 42 of Schedule V.					
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?			<u>Yes-ILU</u> If YES, attach an explanation of the allocation.							
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?			<u>Yes</u>							
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?			<u>Yes-ILU Bldg</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.							
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.			\$	<u>0</u>	Has any meal income been offset against related costs?			<u>No</u>	Indicate the amount.	\$ <u>5,018</u>
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel?			<u>No</u>							
	If YES, attach a complete explanation.										
	b. Do you have a separate contract with the Department to provide medical transportation for residents?			<u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>None</u>							
	d. Have vehicle usage logs been maintained?			<u>Yes</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>Yes</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>							
	g. Does the facility transport residents to and from day training?			<u>No</u>							
	Indicate the amount of income earned from providing such transportation during this reporting period.			\$							
(17)	Has an audit been performed by an independent certified public accounting firm?			<u>Yes</u>							
	Firm Name:			<u>Ernst and Young</u>				The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?			
								<u>No</u> If no, please explain. <u>Not Complete</u>			
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(19)	If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?			<u>Yes</u>							
	Attach invoices and a summary of services for all architect and appraisal fees										